

Hospital-based Practitioner Profile

Practitioner Specialty

Board Certified

Board Eligible

- | | | |
|---|--|--|
| <input type="checkbox"/> Anesthesiology | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Emergency Medicine | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Neonatology | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Pathology | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Radiology | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Hospitalist | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| <input type="checkbox"/> Other (please specify) _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

Are you pursuing Board Certification in the Specialty for which you are applying? Yes No

If yes, when is your date planned? _____

Hospital Affiliation(s) _____

Do you practice exclusively in the hospital setting? Yes No

If no, will members be directly referred to this practitioner? Yes No

Does practitioner practice in an office setting outside of the main hospital? Yes No

Does practitioner have scheduled office hours for members? Yes No

Does practitioner practice exclusively within a free standing facility providing care for members only as a result of members being directed to the facility? Yes No

Practitioner Information Individual NPI _____ Medical License # _____

Name _____
 (Last Name) (First Name) (Middle) (Title)

Social Security # _____ Date of Birth ___ / ___ / ___ Gender _____ Ethnicity (optional) _____

Medicare # _____ DEA # _____ Languages _____

Medicaid # _____ If you do not have a Medicaid #, have you applied for one? Yes No

If yes, when did you apply? _____

Internship/Residency

Institution _____ Type of Training _____

City _____ State _____ Country _____ Specialty _____

Program Completed: Yes No Date of Entry ___ / ___ / ___ Date of Completion ___ / ___ / ___

If not completed, please explain _____

Practice Information

Practice Name _____

Practice Address _____

City _____ State _____ Zip _____ Phone # (___) _____ Fax # (___) _____

Practice Information *(continued)*

Office Manager Name _____ Patient Age Range _____
Credentialing Contact Name _____ Phone # (____) _____ E-mail _____
Credentialing Contact Address _____

Billing Information

Federal Tax ID Number _____ Check to indicate that W-9 form is attached
Name _____
Address _____
Manager Name _____ Phone # (____) _____ Fax # (____) _____
Group/Vendor NPI _____

Form Completed By: _____ **Date:** _____

Photocopy and complete page 1 only for each additional office associated with the applicant's practice.

I hereby apply to become a **Hospital Based** practitioner in the Jefferson Health Plans network.

I certify that all of the information that I have submitted in connection with the profile is true, accurate and complete. I understand that Jefferson Health Plans will rely on this information to evaluate my participation in the prepaid program provided through Jefferson Health Plans.

I understand that any material misstatement or omission of fact on the application is grounds for summary dismissal from Jefferson Health Plans as provided in the Provider Agreement.

I attest to having current, valid malpractice insurance coverage in the amount required by the State of Pennsylvania.

I agree to adhere to the code of ethics of the AMA, AOA, or the _____ (appropriate professional organization of specialty or scope of practice).

I authorize Jefferson Health Plans and/or its designated provider database coordinator to consult with members of the medical staff, affiliate hospitals, professional liability carriers, and health care facilities with which I have been associated. In addition, this authorization includes consultation with other health care professionals who may have information bearing on my competency, character, physical health status, emotional health status, and ethical aspects of my professional practice. I authorize release of such information to Jefferson Health Plans and/or its designated credentialing agent upon request. I agree a facsimile or photocopy of my signature will serve the same as the original.

Signature of Applicant

Date

Print Name of Applicant

Please mail this profile to:

Jefferson Health Plans
1101 Market Street, Suite 3000
Philadelphia, PA 19107
Attn: Provider Database Maintenance

Or fax it to:

215-967-9274

Or email it to:

providerdata@jeffersonhealthplans.com